MONTGOMERY COUNTY HUMAN SERVICES PLANNING & DEVELOPMENT (HSPD)

AUTHORIZATION FOR RELEASE OF INFORMATION AND SERVICE COORDINATION

This release is needed to facilitate, coordinate, plan, fund, and provide Service Coordination for:

Individual's First, Middle, and Last Name	Date of Birth	Social Security Number
Address	City, State, Zip Code	Phone #

SECTION A – AUTHORIZED AGENCIES

Montgomery County HSPD shall follow the privacy regulations of the Health Insurance Portability and Accountability Act ("HIPAA") for use of and protection of my data. All information shall be kept confidential. Only agencies potentially involved in your case(s) will be included in this release. **(Please check the relevant agencies.)**

Check	Organization	Check	Organization
☐	Dept. of Job & Family Services (MCDJFS)	☐	Ohio Department of Youth Services
☐	Montgomery County ADAMHS	☐	Public Health – Dayton & Montgomery County
☐	Montgomery County - Court of Common Pleas (All Divisions)	☐	Human Services Planning & Development-Family and Children First Council
☐	Montgomery County Board of Development Disabilities	☐	Greater Dayton Premier Management
☐	MonDay Community Correctional Inst.	☐	Insurance Co.:_____
☐	Ohio Dept. of Rehabilitation & Corrections	☐	Local School District: _____
☐	**Other:**	☐	OhioRISE (Choices, Inc.)/Aetna

I do NOT want any information shared with the following agencies:

_____ _____

SECTION B – AUTHORIZED DISCLOSURES

The Authorized Agencies identified in Section A have my permission to give/receive/exchange/share the following information, to the extent allowed by law, for the following purposes (specify extent & nature of information to be disclosed):

PURPOSE of Disclosure:

☐ ***for any and all purposes*** relating to any service provided by my Authorized Agencies that I and/or my dependent(s) are currently receiving or possibly eligible to receive,

OR check only the one(s) that apply:

☐ to coordinate treatment,
☐ for continuity of care,
☐ to gather assessment information for treatment planning,
☐ to gather information for ongoing treatment,
☐ for legal matters/purposes,
☐ for reporting progress,
☐ at patient/customer's request (including request to release federal tax information),
☐ for data sharing (including health information exchange),
☐ for mental health, alcohol, and/or drug treatment,
☐ for planning, funding, and providing service coordination,
☐ for other purpose(s) [specify]: _____.

TYPE OF INFORMATION to be Disclosed, please check the ones that apply:

☐ ***for any and all information of every type*** available to my Authorized Agencies,

OR SPECIFIC ITEMS ONLY:

☐ case number(s), contact info (e.g., phone number, email, address), and other demographic info,
☐ identifying info (e.g., name, DOB, address, Social Security number, fingerprints, photographs, etc.),
☐ progress notes (except for psychotherapy notes),
☐ diagnostic assessment information (excluding mental health, substance abuse, and HIV/AIDS-related),
☐ progress in treatment (excluding mental health, substance abuse, and HIV/AIDS-related),
☐ lab results (including urinalysis & breathalyzer, but excluding mental health, substance abuse & HIV results),
☐ attendance,
☐ diagnosis (excluding mental health, substance abuse, or HIV/AIDS-related diagnosis),
☐ financial information (including public assistance)
☐ federal tax information (FTI),
☐ pregnancy testing,
☐ prenatal care,
☐ payment info,
☐ education/address/obligation/benefits history,
☐ other [specify] _____.

Disclosure of SENSITIVE INFORMATION [NO DISCLOSURE is permitted unless box(es) are checked]:

☐ **Psychotherapy notes** ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)
☐ **Sexually transmitted infection** treatment, referrals, diagnosis, diagnostics, and lab results,
☐ **Mental health** treatment, referrals, diagnosis, diagnostics, and lab results (except psychotherapy notes),
☐ **Substance use disorder** treatment, referrals, diagnosis, diagnostics, and lab results:

Explicitly describe what substance use information is to be disclosed and how much: _____.

AMOUNT OF INFORMATION to be Disclosed:

☐ ***for any information for all periods*** of time/treatment, OR check only the one(s) below that apply:
- ☐ information covering the previous three months,
- ☐ information covering the most recent admission on _____ [date],
- ☐ other amount of information [specify] _____.

SECTION C – EXPIRATION & REVOCATION

This Authorization will remain in effect until revoked or as set forth below.

I understand that I may revoke this Authorization in writing at any time by sending a written revocation to Montgomery County Human Services Planning & Development, 117 S. Main Street, Suite 5100, Dayton, Ohio 45422, except to the extent that action has been taken in reliance on this Authorization. If this Authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. **If this Authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or event is stated below**.

☐ **Specify alternative expiration date, condition, or event:_____.**

The HIPAA Privacy Rule requires that an Authorization contain an expiration date, event, or condition that will last no longer than reasonably necessary to serve the purpose for which the authorization is provided. For example, an Authorization may expire "one year from the date the Authorization is signed," "upon the minor's age of majority," or "upon termination of enrollment in the health plan".

SECTION D – CLIENT AUTHORIZATION

By signing below, I voluntarily authorize the **Authorized Agencies** identified in **Section A** to give, receive, exchange, and/or share any information authorized herein, to the extent allowed by law, for the purposes identified in **Section B**. Only staff who have a need to know this information for purposes of providing services or for coordinating services for my case(s) are authorized to give/receive/exchange/share my information. I understand my consent is not mandatory and that I may refuse to sign this Authorization. I further understand that **upon expiration of this Authorization**, **Authorized Agencies will no longer be able to share my information** unless I execute a new Authorization.

Please read and INITAL the following if you understand and agree with each:

_____ *My signature on this Authorization form is strictly voluntary.*
_____ *I understand that I may revoke this Authorization at any time in writing, except to the extent a lawful holder of my information acted in reliance of it. If revoked, it will not have any effect on any actions taken prior to receiving the revocation.*
_____ *I understand that information disclosed by this authorization, except as prohibited by 42 CFR Part 2 or other applicable law may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164.508], and the Privacy Act of 1974 [5 USC 552a].*
_____ *I understand if I do not sign this form, my right to obtain health care, treatment, payment for health care or obtain public services/benefits will NOT be affected.*
_____ *I understand that I have a right to inspect or obtain or copy the protected health information that will be used or disclosed per this Authorization.*

_____ _____ _____
Name of legal guardian (if applicable) Signature of legal guardian Date

_____ _____
Signature of customer/client (adults only) Date

This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client. Generally, the program will not convey to a person outside the program that a client attends or receives services from the program or disclose any information identifying a client unless the client consents in writing, the disclosure is allowed by court order, the disclosure is made to medical personnel in a medical emergency, or the disclosure is made to qualified personnel for research, audit, or program evaluation. Violation of the federal law and regulations by a program is a crime. Federal laws and regulations do not protect any information about a crime committed by a client, either at the program or against any person who works for the program or about any threat to commit such crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state and local authorities. Disclosures of protected health information to non-covered entities will be subject to the minimum necessary guidelines of CFR 42 Parts 160 and 164 and/or the Ohio Revised Code. If the records released include information of an HIV related diagnosis or test result, this information has been disclosed from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without specific, written, and informed consent from the individual to whom it pertains, or as otherwise permitted by state law.

Please send requested documentation to:
Name: _____
Agency: _____
Email: _____
Phone: _____ FAX: _____
Address: _____ City_____ State_____
Zip Code_____